Second Kansas Health Homes Forum
Questions
July 23, 2013
(updated August 13, 2013)

Target Population & Data

Do you have an estimate of the number of persons eligible by county?
You may contact Dr. Theresa Shireman for the information, provided the number is large enough to avoid a violation of HIPAA. Her e-mail is tshireman@kumc.edu .

For the purpose of Health Homes, how is serious & persistent mental health conditions being defined and will it be consistent with the definitions found in the CMHC contract?
It is defined as anyone with the following diagnoses:

Schizophrenia
Bipolar and major depression
Child disintegrative disorder
Delusional disorders
Personality disorders
Psychosis not otherwise specified
Obsessive-compulsive disorder
Post-traumatic stress disorder

Is there a decision tree or formula for making the HH determination?
No, the determination will be made based on mental health diagnoses codes (see above).

Will the State identify the qualified candidates or like WA-will KS send the file to MCO?
MCOs will identify potential HH enrollees based on the diagnoses codes above.

When will we know who the individuals are that have been targeted for the SMI health home?
We hope that Health Home Partners will know of potential enrollees in late fall, but official notifications will go out in January to the enrollees and the HHPs.

Who defines member eligibility-KDHE/KDADS or the MCOs?
The criteria have already been defined by the State, in consultation with the MCOs and our university partners. See above diagnoses codes.

How will we deal with consumers with providers not connected with a particular MCO?
To serve as a HHP, the provider must contract with an MCO. If there are individual service providers working with a HH enrollee, the MCO and HHP will need try to coordinate all service, even those outside the MCO network.

To be in a Health Home will a client have to sign releases of all the people we are to coordinate with that would not be covered by HIPPA (family, significant others, etc.)?
Only if it is required by federal or state statute or regulation.

Will there be "a" Health Home model or will each MCO have a different model?
There is a single model, as defined by the State and outlined in the Health Homes 101 presentation. MCOs may have different agreements with different HHPs, based on the HHP's ability to deliver the core HH services.

Does SMI include SPMI and PRS clients?
It includes anyone with one or more of the diagnoses listed above.

Many consumers with IDD have SMI diagnoses. Will they be included in the SMI Health Homes?

Yes. Anyone with one or more of the listed diagnoses is a potential HH enrollee.

What is the definition you are using for SMI? And does it include children?
See the diagnoses listed above. If children have one or more of these diagnoses, they will also be included in HHs.

On the chart of SMI counts by county (500+), Franklin Co. is listed as 520. Is that Franklin Co. itself or is it Franklin & Miami Co., which the CMHC serves? CMHC is ELC.
Please contact Dr. Theresa Shireman for this information. Her e-mail is tshireman@kumc.edu .

Payment

What is the PMPM rate the MCOs will receive?
The PMPM rate is currently being developed by the state's actuary, Optumas. The deadline for this process is 10-1-2013. In developing the health homes payment to the MCOs, staffing costs, geographic variation, consumer needs and health home partner size will be taken into consideration, as applicable. The PMPM rate paid to the MCO will be published on the Health Homes website once it is established and the State Plan Amendment is approved by CMS.

What progress has been made in setting the reimbursement for Health Home services?
The state reimbursement process to the MCOs is being developed in a two-fold manner:
1. The state's actuary is currently developing the PMPM rate(s) to be paid to the MCOs. The deadline for the rate setting process is 10-1-2013.
2. The state and the MCOs are developing the payment methodology under which the PMPM will be paid by the state to the MCOs. Regional cost factors and a tiered payment structure are some examples of the payment methodology options currently being considered by the state.

Will the HHP know the PMPM paid to the MCO when contracting for a rate to the HHP?
The PMPM rate is currently being developed by the state's actuary. The deadline for this process is 10-1-2013. The rates will be published on the Health Home's website. State health home payments to the MCOs will be structured to be adequate in ensuring quality health homes services are sustainable.

If the HHP receives PMPM only if one or more core services is/are provided in a given month, will the MCO still receive the PMPM?
The state will pay each MCO a PMPM payment for each member enrolled in a health home. Tiered systems of capitated payments based on service delivery are currently being considered as the state develops the final payment methodology. This may consist of a base capitation rate for enrolled members, and a higher capitation rate for service delivery in a given month or quarter. The final payment methodology between the state and the MCO is currently being developed, and has yet to be submitted to CMS for approval.

The state will review all payment agreements between the MCO's and the HHP's. Also, the state will review and approve any non-PMPM payment arrangements between the MCO and Health Home Partner.

What incentive does the HH have to improve the individual outcomes? (Shared risk)
Any non-PMPM payment arrangements between the MCO and the HHP will be reviewed and approved by the state.

Can the potential Health Home provider's contract with MCOs past the 1/1/14 date? (For example, could HH partner "A" contract with MCO-Y on 11/15/13 and MCO-Z on 2/15/14?)
Yes

Will PMPM differ according to Medicaid category of consumer?
The state's actuaries are still developing the PMPM rates for the first Health Homes population, SMI. It is likely the SMI PMPM rate will differ from the rate developed for subsequent Health Home populations.

Will the State consider a risk adjustment methodology for MCO/HH based on an aggregate activity of each MCOs population?

The state is developing the payment methodology under which the PMPM will be paid by the state to the MCOs. Regional cost factors, risk adjustment factors and a tiered payment structure are some examples of the payment methodology options currently being considered by the state.

Can the HH payment subgroup commit to delivery of a list of reimbursement variables that will not be addressed by the subgroup for 1/1/14 by 11/15/13? (e.g. one that we know is that the State will not approve PMPM arrangements between MCO & HH partners. Are there other items like this?)
Yes, this is possible.

Is there any consideration to basing PMPM as a payment regardless of how many core services are provided, and have HHP receive incentives based upon outcomes? So, base PMPM for being the HHP, then receiving PHP based upon patient outcomes? (If you are interested, the state of Maine has done this for years for their PCCM program)
The state is considering these alternative payment methodologies.

Will the HH be aware of the PMPM rate the MCO receives?
Yes. Once the State Plan Amendment is approved by CMS, the rates will be published on the Health Homes website.

Is there any incentive for MCOs to use Health Home partners vs. provide the 6 services themselves?
The PMPM will not be developed to provide such incentive. The decision as to which entity will provide the core services will be a negotiation between the MCO and the HHP.

Will payment to providers be equal between MCOs?
No. The state will not direct all payments to be equal. The payment rates between Health Home Partners and the KanCare MCOs are direct negotiations that will take place between those two entities.

Will MCOs be able to withhold payments to Health Home partners based on outcomes?
No. However, the state will review and approve any non-PMPM payment arrangements between the MCO and Health Home Partner.

Describe in greater detail the latitude the State will allow the MCOs in payment plans for HH.
The payment rates between Health Home Partners and the KanCare MCOs are direct negotiations that will take place between those two entities. The state will review and approve any non-PMPM payment arrangements between the MCO and Health Home Partner. The payment structure between the MCO and the Health Home Partner will be a sub-capitated payment structure and will be reviewed by the state for reasonableness.

What payment methodology will be used by MCOs in reimbursing Health Homes for their services? (i.e. will various care management or coordination of services be reimbursed at differing rates and on a fee for service basis?)
A sub-capitated payment structure will be used by the MCOs to pay the health home partners.

Is the shared payment to HH just a sub capitation of the rates the MCO gets?
Yes**.**

Will there be a required amount or % the MCOs will be required to pass on to HHP?
No. The payment rates between Health Home Partners and the KanCare MCOs are direct negotiations that will take place between those two entities. The state will review and approve any non-PMPM payment arrangements between the MCO and Health Home Partner. The state will also review the sub-capitated payment to the HHP for reasonableness**.**

Why are the MCOs getting the PMPM when providers can likely manage the population better?
The state has determined that the PMPM will be paid to the MCO because they are already managing all the services provided to KanCare members and pay for those services so they have all the data for all services provided. We also want a broad range of HH Partners and the MCOs have the capability to support a variety of providers to serve as HH Partners.

When will MCOs have PMPM amounts negotiated with the Health Homes?
The goal is to have the PMPM rates completed by 1 October 2013.

Since rates are currently established for many behavioral services (i.e. CPST, psychosocial, peer support) Will these change?
No.

Services

The Care Coordination services provided in Health Homes are typically thought to be face to face (nationally). Does KanCare agree?
Generally, yes; however, there may be legitimate reasons to include telephonic and other types of contacts in the course of delivering care coordination services.

Does the enrolled individual have any input on who their "dedicated care manager" is?
HH enrollees will have a choice of health homes, including the MCO and the HHP.

Will the existing MCO service coordinators or case managers be providing the care coordination?
Depending upon the HHP, the MCO could be providing care coordination or it could be done by the HHP. The agreement between the MCO and the HHP will spell that out.

What Home Health Core Services do the MCOs envision themselves providing and which ones do they believe they will contract with a Health Home partner?
There are no services reserved exclusively for the MCOs. HH Partners who contract with the MCOs and demonstrate that they can provide all six core services could do so, if both parties agree to that.

What entity(s) has responsibility for State psychiatric hospital admission, treatment, discharge and payment?
CMHCs will still perform the screenings for admission to State psychiatric hospitals. HH members who must be admitted to these hospitals will still be eligible for HH services in order to ensure comprehensive transitional care – one of the six core HH services. Payment for State psychiatric hospital stays will not change under HHs.

In the Health Home model, what is the role of Cenpatico and Optum in delivering the 6 core services in partnership with HHP's- particularly since the first population is SMI?
As MCO subcontractors for behavioral health services they will support HH partners in the delivery of HH services.

Do MCOs see possibility of contracting with CMHC outside of client's catchment area for service delivery? (i.e. what if local CMHC doesn't offer co-located physical healthcare services, but another CMHC does?)
CMS requires that HH enrollees have choice of HH providers. We interpret that to mean both a choice of MCO and a choice of HH Partner.

How is a Health Home any different from the promise of KanCare, better coordinated care=better health outcomes for all people? Isn't this an admission that regular KanCare doesn't work?
A health home is even more intensive care management and care coordination that focuses on members with certain chronic conditions. Not everyone in KanCare will have a condition that requires a health

home. Health homes were always included as a component in KanCare, but were not intended to launch until the second year of KanCare.

What is the difference between Health Home and NFMH? It sounds the same.
A health home is not a residential setting, nor is it all services provided by a single provider. It is a comprehensive and intense system of care coordination that integrates and coordinates all services and supports for people with complex chronic conditions.

Can a Health Home service provider sub-contract with the MCO and a Health Home partner?
Yes.

With working with all 3 MCOs, will there be standard forms across the board? (ex. All the same form when addressing the health action plan. Same assessment piece.)
The state has directed the three MCOs to work together to ensure that forms and processes related to health homes be as consistent as possible. We are also open to suggestions from providers as to how to help with that.

Will the MCO's be "allowed" to exclusively offer any 6 of the services?
No.

Are the MCO's currently considering HHPs other than CMHCs for the initial SPA? Particularly to meet the special/unique needs of those members with dual diagnoses or co-occurring diagnoses?
Yes, and the state is encouraging a wide variety of HH partners.

If a person is in a NF/MH and they opt out of HH, will they lose their benefits?
No.

What are the "new" services definitions the State will create if the HH services are different from KanCare? (behavioral health)
The Centers for Medicare and Medicaid Services (CMS) requires HHs to provide six core services. These are:

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up
- Individual and family support
- Referral to community and social supports
- Use of HIT to link services

These are the services the State must define and has done so. See the draft services definitions document here: http://www.kancare.ks.gov/download/Health_Homes_Draft_Service_Definitions.pdf

Will the State advocate for case management in the ID/DD setting to approve a limited provision of total case management concurrent to the HH service?
We do plan to discuss with CMS the unique role that case managers have played with this population; however, many of the tasks performed by case managers - as defined by the federal government and in the Kansas Medicaid State Plan – are now included in the definitions of the six core health home services, so case managers could sub-contract to perform one or more of the HH services.

Has the State had an opportunity to speak with CMs about Health Home service definitions that don't cover all the unique duties of an ID/DD case manager?
We have not had direct conversation with CMS since our early calls where they told us "no one who received HH services can also receive targeted case management." We have had discussion with staff at the Center for Health Care Strategies, the CMS HH technical assistance contractor, about how we can approach further discussion of this topic.

The HH vs. TCM issue is obviously unsettling for many participants. Is there an avenue for stakeholders to give feedback to CMS regarding potential unintended consequences and advocate for some concessions/exceptions/alternatives?
The State must solicit public input into the SPA, which will be posted on the KanCare website. CMS will review the input.

Will community mental health centers be the only entities contracted to provide behavioral health HH services? Or will other behavioral health providers offering MH/SUD services be able to partner for HH services?
No, although we encourage all CMHCs to become HH partners since they are well-placed to serve the SMI population due to their expertise. Additional providers can become HH partners if they meet the standards and qualifications and are willing to contract with the MCOs.

Will the service division be similar between MCOs?
Not necessarily. The State wants health homes to be developed in as flexible a manner as possible to ensure they can meet the unique and varied needs of the population who will be served by them. In addition, not all potential HH Partners have the same capabilities.

How does having 2 separate SPAs facilitate the goal of integrated behavioral and physical health?
It is expected that the target population defined in the second State Plan Amendment (SPA) will be much larger than the SMI population and require a broader range of providers to serve as HH Partners. Integration of behavioral and physical health care will still be required for that population as well. That does not mean that everyone must have the same type of HH partner.

Is there going to be incentive for consumers who opt (in) to be part of Health Home and as a result their health costs went down? (Consumers need to be encouraged to reduce costs)
The approach Kansas is taking to HHs is not an "opt in" approach, but rather a passive enrollment, "opt out" approach. So the person would be assigned to a HH and then have to opt out if he or she did not want to participate. The MCOs are well-placed to offer incentives to HH enrollees and already do so in the KanCare program.

Does the health action plan have to be a separate document from the SMI clients' state-required treatment plan? Can it be consolidated?
It is a separate document that will incorporate information from the treatment plan.

Do you plan to have any specific required assessments in the health home (i.e. WA requires PAM)?
We expect HHs to perform a complete biopychosocial assessment on the individual, as well as to use whatever other assessment data has been gathered by various providers and made available to the HH. The PAM is a tool to assess how involved the patient is becoming in his or her health care. It is certainly not going to be prohibited, but will not be mandated.

Is it the expectation for there to be one rehabilitation plan that would meet the test for both a CMS treatment plan & a person centered action plan?
Kansas will require a Health Action Plan that incorporates components from other state-required plans. Various service systems, e.g. mental health, I/DD, substance use disorder treatment, all have specific plans they must produce for their licensing entities and HH partners could come from any of these systems or others.

Will the Health Homes Care coordinator be the same care coordinator that people on HCBS waivers already have? Or will they have 2 care coordinators?
The provision of care coordination will be negotiated by the MCO and the HH Partner. The Care Coordinator may be at the MCO or at the HH partner.

Can a HH decline to provide a service(s) to a person referred by a MCO?

One of the requirements for becoming a HH Partner is not refusing someone who is eligible and assigned to the HH Partner, except for very narrow reasons. Generally, HH enrollees will be assigned based upon their experience and relationship with available HH partners in the MCO networks.

When will people with primary condition of substance dependence go into Health Homes?
Many people with SMI also have co-occurring substance use disorders. The HH is responsible for approaching the enrollee's health issues holistically, regardless of what type of provider the HH partner is. Substance use disorders are also be analyzed as part of the research into the second target population for HHs, beginning in July 2014.

Will the Health Home community provider have to provide transportation to appts (PCP & specialists)? Will we be expected to go in person to each appt or specific ones? If so, who will determine this?
No. NEMT is still available to HH enrollees as part of the KanCare program. There may be times when it would be helpful for someone from the HH to accompany the enrollee to a certain appointment. The Health Action Plan and individual circumstances will help determine that.

They are going to negotiate the PMPM between MCO & HHP on each consumer?
It would be impractical for the MCOs to negotiate payment for each HH enrollee. Generally, the MCO will negotiate payment per each HH partner, based on a variety of factors, including how many of the six core services the HH Partner will be performing.

What would be an example of "other services" that would still be provided by a CMHC and billed to the MCO?
Any of the services currently listed in the Medicaid State Plan and covered under KanCare, such as Outpatient Therapy, Community Psychiatric Support and Treatment, Peer Support, etc.

One of the objectives of HHP is to provide community & social supports for members to enhance their well being. How will you (MCO) provide incentives for the members to participate in their well being? What will happen if the member refuses or is reluctant to participate in their well being with the HHP?
MCOs already provide certain incentives for members to complete certain wellness and prevention activities, so they are well-placed to provide other incentives for HH enrollees. Since health homes will be a State Plan service, CMS will likely not allow health homes to disenroll HH members who are non-compliant.

How will it be determined/decided what MCO will do & what HH partner within 6 core services?
This will be negotiated between the MCO and the HH partner.

Will the State send a list of people eligible for HH to providers so they could help the enrollees understand what is going on?
Yes, we will examine how we can do this near the time when potential HH members are notified.

When will the enrollment letter go out to enrollees?
There is no specific date, yet, but the letters will need to go out before January 1, 2014.

If you are a HHP, do you have to provide HH to both SMI and chronic diseases clients? Can you choose not to do SMI?
No, you do not since there will be two different SPAs for the two target populations. A HH partner can choose to provide HH services either to the SMUI population or those with other chronic conditions, or both.

When a FQHC & CMHC are co-located & a SPMI consumer is using services from both agencies- which agency is the Health Home?
CMS requires that HH enrollees be provided a choice of HHs.

If member has both SMI & diabetes (after July 2014), what is the designated Health Home? CMHC vs. physical care agency?
The HH enrollee would have a choice of health homes.

How will the HHP or MCO know what each consumers needs are to begin with?
The MCOs already must complete a health risk assessment (HRA) on each KanCare member, so they will have that information to begin with. In addition, a complete biopsychosocial assessment will be completed to help develop the Health Action Plan (HAP).

Having 3 contracts (one w/each MCO) for CMHC will be confusing for consumers. How will the state address this confusion? Is this an issue for your consumer focus group?
Contracts and agreements between providers and MCOs should not be an issue for consumers, unless providers or MCOs make them aware of such agreements and contracts. There is no need to do so. Consumers will be informed of their opportunity to participate in a HH and who the potential HH partner is. In addition, they will be provided information about how to opt out and how to choose a different HH partner should they wish to do so.

If a provider is already contracted with an MCO (Sunflower, Optum, Cenpatico) does this mean the provider is already contracted to be part of the Health Home network? What does the provider need to do to become part of the system?
The MCOs have indicated that providers who already have contracts with for KanCare would likely only need an addendum to the contract to be a HH partner; however, they must meet the HH partner standards and qualifications and be able to provide one or more of the six core HH services. Providers interested in becoming HH partners should contact the MCOs. Contacts for each MCO will be provided soon. In the meantime, you should talk with your designated provider representative to let them know you are interested.

What happens to patients going in & out of Medicaid once they are part of a HH?
This will be a problem, but CMS does not allow states to exclude eligible enrollees from HHs. It will be important to ensure that members who lose eligibility are reattached to the same MCO and HH if the member re-attain eligibility within six months.

When will new billing codes and descriptions of codes be sent out so EMRs can be updated for the Jan 1 start up?
There will not be a set of new codes. Health Home is a bundled service. There will likely only be a single code that will be used to trigger the PMPM for HHs. Providers will be notified of this code as soon as it is confirmed, most likely the first part of September.

If we are currently providing case management, will it be paid as KanCare or Health Home?
CMS has stated that people in health homes cannot receive targeted case management as a separate service. They view these two services as duplicative. For someone in a HH, their case management would be part of the core HH services.

HIT

Does the State have plans for disease registry and prescription possession ratio system?
The State will not maintain any health information databases. We expect MCOs and HHPs to use their exsiting tools , as well as the state health information exchanges (KHIN and LACIE) to share information.

MCO coordinate thru KHIN on HIT issues so providers have one entry point to health records and plans of care vs. having to access 3 different sites w/potentially 3 different passwords and 3 systems to manage administration/access of. (This work is being done already w/KHIN helps w/consistency of forms and information being shared. Very concerned of IT burden on local providers and patients)
The State expects MCOs and HH Partners to use the existing health information exchanges to share information.

Will the 3 MCO electronic records "talk" to each other? (If a client moves from one MCO plan to another, will all the information be lost? How will the MCO system talk to the agency system and KHIN? Who will pay for an agency link?)
See the previous question and answer.

How does the HIT requirement for Health Homes (and KanCare for that matter) tie into the State's current effort for Health Information Exchange? (The efforts are the same and shouldn't be in isolation from each other and shouldn't create a new & different data systems)
Kansas has two certified state health information exchanges, the Kansas Health Information Network (KHIN) and the Lewis and Clark Information Exchange (LACIE). The state expects MCOS and HH partners to work toward using these exchanges to share information across providers. HH Partners should have or be in the process of developing/acquiring an electronic medical record that will be able to interface with either of these exchanges.

Will all Health Home providers be required to have Health Information Technology? Be able to access or provide records electronically?
Yes.

Will MCO be able to implement a shared access system for Health Homes partners so all partners have access to patient data (with patient consent)?
Use of either of the two certified health information exchanges, , the Kansas Health Information Network (KHIN) and the Lewis and Clark Information Exchange (LACIE), allow for this exchange of information.

What type of IT software will be needed to "link" or "interface" with other service professionals within the Health Home?
Kansas has two certified state health information exchanges, the Kansas Health Information Network (KHIN) and the Lewis and Clark Information Exchange (LACIE). The state expects MCOS and HH partners to work toward using these exchanges to share information across providers. HH Partners should have or be in the process of developing/acquiring an electronic medical record that will be able to interface with either of these exchanges.

Everyone recognizes that the barriers to effective and efficient EHR are systems that don't connect and talk to each other. Why are we seeing 3 MCO systems being developed that apparently don't talk to each other?
Each MCO has developed proprietary software to be used internally, but they are all required, contractually, to be able to link to the two certified health information exchanges (KHIN and LACIE) and to help their contracted providers to also do so.

Would it be possible for all MCOs to use 1 system for HIT?
Each MCO has its own care management/coordination software, but the State expects MCOS and HH Partners to use the state health information exchange

For all MCOs-Will HH providers be able to run any reports for care gaps & alerts within the clinical portals for all patients for whom we are HH or is it individual patient query only?
Amerigroup will initiate this by including all of the Health Home providers in the distribution of various reports that indicate a gap in care needs (KAN Be Healthy exams, immunizations, HEDIS-type measures, etc.)

Sunflower - All Primary Care Providers (PCP's) and designated Health Home providers with authorized portal access are able to view, print, or export to Microsoft Excel a list of all Sunflower Members in their care, and they are able to filter Member data to list only those Members with care gaps/alerts. We are currently expanding this reporting functionality to include the ability to filter the Provider panel to report Members with special healthcare needs, including chronic conditions and disease states; for example: Heart Disease, Developmental Delay, Physical Disability, or if our Member has a visual or speech

impairment). All other authorized providers are able to view care gap information when they search for a specific Member through our Member eligibility search function. This functionality supports our providers in their effort to outreach to Members and assist those Members in the event of a crisis situation.

United - It is our expectation that the providers (health home partners) will be able to access their members by individual query, but are hoping to provide a group identifier which would allow a filter for the HH members.

Sunflower Plan-Who has access to the member health record? Only patient/members?
All providers with authorized access to our Sunflower clinical portal are able to view the Member health record, which includes: care gaps and alerts, visit history with primary diagnosis, medications, lab information, immunizations and allergies, when we have this information. Providers are also able to view any completed health assessments, and Care Plans used by our care managers.

Members are able to view their care gaps and alerts, as well as their visit history through the on-line claim functionality. Additionally, we are in the process of making available specific Care Plans for Members available on our Member Portal, for those Members in case management who have specific conditions, such as diabetes. Care Plans for our Members are presented in language that is easy to understand, with defined, measurable goals. We also provide our Members with the ability to create and maintain their own electronic Personal Health Record (PHR) using the Microsoft HealthVault service. For Members who create a HealthVault account and notify us of this, we have their claims and pharmacy claims data securely sent to their Microsoft HealthVault account – for viewing and use by the Member or anyone to whom the Member delegates viewing authority.

Will the MCO require the provider to enter clinical twice-once for their HIT systems & our EMRs?
Amerigroup proposes that providers bill the CPT or HCPCS code designated by the State to indicate a Health Home provider encounter and then document in the patient record (according to the documentation standards) rather than duplicate patient information in multiple places.

Sunflower - We do not ask our providers to enter clinical data twice; we enable information exchange with our providers leveraging the capability that they have available to them.
For all our providers who have internet, we offer access to our secure, web-based Provider Portal which allows providers to perform self-service, administrative transaction services online via the internet; such as check eligibility, submit authorization requests, submit batch HIPAA claims and/or supporting attachments and documentation, enter claims online, view explanations of payment (EOP), register for electronic payment (EFT), and a variety of other functions.
As it relates to other medical information, all authorized Providers are able to view our Member Health Record which organizes health information for our Members that we have available to us including: HIPAA compliant medical and behavioral claims, demographics, data, and lab results that we obtain via HL7 interface with our lab providers, completed assessments, care gap and alert information.
Additionally, for those providers who have their own Electronic Health Record, these providers will be able to print the MHR as a PDF and/or securely export the MHR from our portal in Continuity of Care Record (CCR) or Continuity of Care Document (CCD)* format (if the provider has a standards-based EMR or viewer to use the CCR or CCD data).

(*) In process

United – At the present time, our Community Care Manager is a stand-alone application.

The MCOs appear to all have their own proprietary software for managing and reporting health home HI. Will provider partners simply log on and document services for no charge? Will providers need to purchase any software to manage care?
Amerigroup proposes that providers bill the CPT or HCPCS code designated by the State to indicate a Health Home provider encounter and then document in the patient record (according to the documentation standards) rather than duplicate patient information in multiple places.

Sunflower - As mentioned above, all providers with internet access who are registered users of our Provider Portal are able to perform self-service, administrative transaction services online via the internet, *at no charge*. These services include: check Member eligibility, enter claims online, submit authorization requests, submit batch HIPAA claims and/or supporting attachments and documentation, etc. Providers do not enter clinical notes into our Member Health Record, rather we display information to our providers based on medical and behavioral health claims, and other data we have available, such as pharmacy and lab data, completed assessments, and care gaps and alerts based on reports from our Centelligence™ Foresight suite of predictive modeling tools.

We will be making available to our network of PCPs a growing number of reports* *at no charge.* For example, the following reports are or will be available on-line in 2014: high cost Members, PCP pharmacy detail by patient, pharmacy summary by Member by PCP, Emergency Room (ER) frequency, ER Early Alerts, ER Visit Follow-Up, Non-emergent ER, Members not Seen by PCP, etc. Providers do not need to purchase software to view these reports; they will be available in pdf format.

(*) In process

United - United's Community Care Manager is proprietary. The MCO's are currently having discussions on documentation processes, and more information should be available as the Hit/HIE integration advances.

Is it required for Health Home providers to have EMR? What is "demonstrate a capacity to use health information? (i.e. KCPC for SED)
The State, and CMS, expects that HH partners will develop capacity to have an electronic medical record that will be able to feed information into one of the two certified state health information exchanges (KHIN and LACIE).

Quality

Reporting Outcomes to State and MCOs-Will there be one standardized form for this? Otherwise will be spending more time, energy & money on measuring and writing reports than on providing services to our clients.
The processes for reporting quality measures will be standardized and the sources utilized to collect the data are defined in the 'Proposed Kansas Health Homes Quality Goals and Measures'. A standard form for providers to report to the State and MCOs has not been developed, to date, but this suggestion will be considered.

Measurements of Outcome-What standardized measurements are being considered? Will all 3 MCOs require/utilize the same measurement instrument? (Would be more manageable and efficient)
The standard measurements under consideration are included in the document titled 'Proposed Kansas Health Homes Quality Goals and Measures', found here:
http://www.kancare.ks.gov/download/HH_Forum_Document_Goals_and_Measures.pdf . The first five pages contain the draft State Quality Goals and Measures and pages 6 and 7 include the CMS Core Quality Measures.

Will the State require that all MCOs use the same reporting information?
Yes, all three MCOs will report on the same defined measures with associated numerators and denominators.

Operations
Are you going to post answers to the questions asked today on the website?
Yes

Will the 3 MCOs use identical billing, monitoring, outcome measures and credentialing processes, tools, forms, etc.?

The three MCOs have been directed by the state to work together to develop consistent processes. Regarding credentialing, the MCOs have indicated that providers who already have contracts with them and who want to be HH partners would need to sign an addendum to their existing contract.

How many Health Home partners do you project in Kansas?
We do not have a projection of numbers since we do not know how many of the 36,000 potential HH enrollees (of the first target population – SMI) will decide not to opt out.

Seems like patients would be more engaged in an "'opt in" environment. Will we learn strategies to increase engagement? If patients don't cooperate & follow through (as many do now), are there consequences to the patient?
Experience in other states that chose the opt in approach indicates a very low take up rate for health homes. We want to get as many people as possible into HHs and hope they will see the benefit as they receive the HH services.

Are there milestones for MCOs that need to be met such as 80% network providers in place by "X" date?
Not at this time.

Provider Qualifications
If they are looking at the costs of services and we know mental health costs are typically higher than substance abuse services, how will a SA provider ever get to be an option of HHP? Even if they could provide good services.
Any Medicaid provider who can meet the HH standards and qualifications and who can provide one or more of the six core HH services is a potential HH partner.

If an adult care home (licensed) signs agreements to be a HH provider, will that guarantee they will be the HH partner that coordinates necessary services?
No. CMS has some specific requirements related to nursing facilities serving as health homes and has stated:

> CMS will consider health home proposals that propose to improve outcomes and change the trajectory of those Medicaid individuals in a nursing home with one or more chronic conditions such as mental illness/behavioral health conditions. CMS would also support health home efforts to transition Medicaid individuals out of a nursing home, since that is a specific part of health home services. However, the State would need to develop coverage, payment and evaluation methods to ensure that the health home services do not duplicate ordinary nursing facility services. To the extent that health home payments were made to nursing facilities, the State would need to ensure that the health home payment was for services above the level of the services which the nursing facility was already obligated to furnish under the applicable nursing facility conditions of participation and the nursing facility payment rate. For example, the State might need to distinguish between normal nursing facility discharge planning and transitional care efforts that exceed the level of discharge planning.

What is member to nurse ratio?
At this point there is not one. In the development of the payment methodology, staff to member ratio will be considered.

What are the expected qualifications of care coordinators and case managers? How will they be trained to ensure consistency in care across KS?
Those are still be determined. It is expected that we will build on already established requirements for these professionals. Training will be provided by both the MCOs and the HH partner agencies.

What Health Home qualifications have been identified?
Please refer to the draft standards found here:
http://www.kancare.ks.gov/download/KanCare_Health_Homes_Provider_Standards_Draft.pdf
Additional professional qualifications will be published soon.

Are there limitations of what type of facility/organization can be the designated health home? (e.x. health care facility, community service provider, faith-based organization, state/local sub-programs, etc.)
Any Medicaid provider who can meet the HH standards and qualifications and who can provide one or more of the six core HH services is a potential HH partner.

Possible request: A HHP readiness checklist (uniform tool) would help potential HHPs evaluate their capacity.
This a good idea. There are some assessment tools already available that potential HH Partners could use. One is found here: http://old.thenationalcouncil.org/galleries/business-practice%20files/Provider%20Readiness%20Assessment.pdf
We will look at developing a tool specific to Kansas.

Will MCOs see the need for HHP to view data as a paid care management function? Even if they maintain and analyze the data? What about the need for coordinated team meetings with various HHPs?
HHPs will be paid a sub-capitation payment or PMPM by the MCOs; the HHP will not bill fee for service for each discrete core service provided. HHPs will likely not be meeting with each other, unless they also provide other service, e.g. behavioral health services covered by KanCare. Whether or not the MCOs will have meetings with their HHPs should be spelled out in the MCO-HHP contract.

Can a HH decline to enroll a person referred by a MCO?
No. One of the requirements to be a HH partner is not refusing to serve a referred HH enrollee, except in cases where the safety of the enrollee or health home staff is at serious risk.

Will the HH be aware of the PMPM rate the MCO receives?
Yes. CMS requires that we publish/post the health homes rate methodology.